

St Anne's Community Services

St Anne's Community Services - Glenholme

Inspection report

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Date of inspection visit:
22 June 2016

Date of publication:
12 July 2016

Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection took place on 22 June 2016 and was unannounced.

The last inspection of this service took place in January 2014. The service was found to be compliant with all of the legal requirements inspected at that time.

St Anne's Glenholme is a respite service which can provide short stay and respite accommodation for up to 14 people at any one time. At the time of inspection there were nine people living at the home.

There was a registered manager in position. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

From our observations and speaking with visitors and social care professionals we concluded people were safe living at the service. Risk assessments and safeguarding procedures were in place and up to date. We saw evidence of consent and best interests meetings where appropriate.

There was a robust system for monitoring and detailing accidents and incidents with lessons learned and action plans in place where required.

Medicines were generally managed safely although some improvements were required in the layout and auditing of the Medicines Administration Records (MARs) in order to comply with current guidelines. Management of 'as required' (PRN) processes needed to be more robust. However, from observing immediate systems changes being implemented during the inspection, we felt confident these improvements would be made.

Staffing levels were good and responsive to the needs of the people living at the service. A robust and safe recruitment process was in place and staff training was up to date, with service specific training available.

The premises were clean, comfortable and well maintained. Any issues were reported in a timely manner.

People's dietary requirements were being met and the service offered a varied rolling menu which people enjoyed.

People had access to a wide range of health care professionals and there was appropriate equipment in place to assist with people's care needs.

During our inspection we observed many positive interactions between staff and people that use the service. People appeared happy and the atmosphere in the service was calm and relaxed.

Staff knowledge about people living at the service was excellent and their approach was kind, caring and respectful of people's privacy and dignity.

Care files were detailed and person centred and we saw evidence care plans were put into practice by staff. Care files were reviewed regularly.

Varied, person specific activities were offered, with people choosing what activities they wanted to pursue, with a number supporting and promoting people's independence.

The service had a robust complaints procedure in place although no official complaints had been made since July 2015.

People we spoke with praised the staff and management team. The registered manager was approachable, well respected and was a visible presence in the service. Morale in the service was good and staff told us they felt supported.

Service audits were in place and up to date and there was regular support from the provider to ensure quality of service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

The medicines management system needed to be more robust.

Effective safeguarding procedures were in place and risk assessments were up to date.

Staffing levels were good and responsive to the changing needs of the service. A robust recruitment process was in place.

Is the service effective?

Good 

The service was effective.

A robust system of training and development was in place, including service specific courses and staff supervisions.

Staff worked with external health professionals to ensure people's healthcare needs were met.

Care files contained evidence of consent sought and best interest's meetings held.

People's nutritional needs were being met.

Is the service caring?

Good 

The service was caring.

Staff had good knowledge and understanding of people including likes, dislikes and care needs.

People were treated with dignity and respect.

People's independence was encouraged.

Is the service responsive?

Good 

The service was responsive.

A wide range of person specific activities were made available,

according to people's choices.

Care plans were detailed and person centred and people received person centred care.

A robust complaints procedure with action plans was in place.

Is the service well-led?

Good ●

The service was well led.

The registered manager led by example and was well respected by people, staff, visitors and healthcare professionals.

Morale within the service was good.

A robust system of audits and quality assurance was in place.

St Anne's Community Services - Glenholme

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 June and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information before the inspection. We also reviewed the information we held about the home which included looking at information we had received about the service from the local authority and commissioners as well as statutory notifications we had received from the service.

During the inspection we spoke with one relative, two care staff, the registered manager, the deputy manager and a social care professional and spoke informally with four people that used the service. We reviewed three people's care records, some in detail and others to check specific information, four staff files, medicines records, staff training information as well as records relating to the management of the service.

Is the service safe?

Our findings

From speaking with staff, visitors and social care professionals and observing people at the service, we concluded people were safe. People looked relaxed and comfortable with staff. A relative told us, "I know if I go away I feel safe knowing [person] is here."

A healthcare professional told us, "I know people are safe. It's a nice quiet, safe area. Staff are with them. They watch them when they're outside and staff go with them when they go into town."

Safeguarding procedures were in place. The registered manager demonstrated a good understanding of safeguarding and how to identify and act on concerns. They told us no safeguarding incidents had occurred within the service since January 2016. This reflected the safeguarding notifications received by the Care Quality Commission. We saw safeguarding was an agenda item on staff meetings to help support staff to raise any concerns and keep them informed of updated safeguarding policies and procedures. Staff had received safeguarding training. Staff we spoke with had a good understanding of how to identify and respond to any suspected abuse or concerns they had about people's wellbeing.

People's care records contained information around areas of potential risk to people. Personal emergency evacuation plans were in place which indicated how to support a person in the event of an evacuation. Other areas of identified risk included manual handling, choking, incontinence, pressure care, epilepsy and refusal of medication. Some of the risk assessments we saw were documented on 'positive risk assessment' paperwork. This meant that risks could be judged to see if the positive effect of the person completing a certain activity outweighed the potential risk of something happening. For example, we saw one person had a positive risk assessment for choking. This documented that certain foods had a higher chance of making someone choke than others. However with the support of staff, the benefits of this person eating what they wanted outweighed the risk of choking.

Risk assessment documentation recorded the identified risk, a rating indicated the severity of risk, who the risk effected, benefits to doing the risk and how to reduce the risk. All risk assessments we looked at had been recently reviewed and changes were made to reflect people's changing needs. Environmental risk assessments had been completed by the provider and were reviewed on a regular basis.

Accidents and incidents were clearly documented and appropriate actions were seen to be taken as a result, such as reviewing the person's risk assessments and care plans. Accident and incident forms were reviewed by the area manager with further actions recommended where appropriate.

Medicines were administered to people by trained care staff. We inspected medication storage and administration procedures in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Medicine fridge temperatures were taken daily and recorded.

Some changes were required to the medicines administration charts (MAR) to ensure safe management of

medicines. The NICE (National Institute for Health and Care Excellence) guideline 'Managing medicines in care homes' (March 2014), section 11 states, 'Pharmacies supplying medicines to care home providers should ensure they have processes in place for all staff who dispense and accuracy check medicines for residents, particularly those using monitored dosage systems' and, 'Supplying pharmacies should produce medicines administration records wherever possible.' The service had devised its own MAR charts and was not using the MAR charts provided by the pharmacist for medicines contained in dosette boxes. The registered manager did not have a copy of the current NICE guidelines regarding medicines management and explained that a pharmacist had told them during an independent medicines audit two years previously to state 'dosette box' on their own MAR chart and sign to indicate dispensing of contents. This was not in line with the NICE current guidelines. We were unable to verify this information with the pharmacist since they were no longer employed at the pharmacy from which medicines were dispensed. We saw on four people's MARs it stated 'dosette box' rather than the specific information about the contents, although an information label about each medicine including a description of how it looked was attached under the lid of the dosette box. No stock audit had been completed for medicines stored in dosette boxes although we observed that the labels on the underside of the dosette boxes stated the amounts initially dispensed by the pharmacy.

We saw the service had an 'as required' (PRN) medicines policy in place and appropriate documentation was present in the medicines file. However, we observed that some PRN medicines were entered on the standard medicines MAR rather than the service specific PRN form. Some PRN documentation was not fully completed, for instance the reverse of the PRN form which asked for further information on the circumstances the medicines should be given. This meant there was no clear guidance in place for when or why such medicines should be given.

We discussed our concerns with the registered manager and senior care worker responsible for administration of medicines on the day of the inspection. They agreed with our findings and to implement changes to the system immediately to ensure medicines management complied with recommendations from the NICE guidelines and PRN documentation was completed more robustly. During the afternoon of the inspection we were shown a revised MAR chart reflecting actions already taken to reflect this and we were assured these medicines would now be included in the daily medicines stock checks. We concluded the registered manager had taken appropriate and immediate steps to ensure the service was compliant with medicines management.

We saw there was a clear system for recording medicines ordered and collected, of medicines booked in and out of the service for those people attending day centres and a stock check of most medicines was being undertaken each day and night.

Where people's medicines had been changed, we saw evidence of medicines reviews and signed instructions from the GP or psychiatrist in the medicines files.

Creams and ointments were prescribed and dispensed on an individual basis and were properly stored. At the time of inspection only one person had been prescribed creams which they had brought in with them from home. We saw there were clear instructions on the MAR chart where the cream should be applied, although a body map was not present. The senior care worker responsible for administering medicines on the day of the inspection agreed that body maps could be utilised to ensure ointments were applied accurately.

Some prescription medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two

appropriately trained staff.

We carried out an audit from a random sample of four medicines dispensed in boxes to account for their use or accuracy of recording and found no discrepancies.

We looked at staffing records. Safe recruitment procedures were in place to ensure staff were of suitable character to care for vulnerable people. Staff were recruited in line with the provider's policy with some documentation being stored at the head office. We looked at four staff files and saw all staff attended an interview, had proof of identity documents and at least two positive references. The service also carried out a Disclosure and Barring Service (DBS) check on all candidates to confirm they were suitable to work with vulnerable people. Where staff had gaps in employment this was explored and recorded.

We asked the registered manager how they managed staffing levels within the home. They told us they reviewed levels according to people's dependency and how many people were at the service. We looked at the rota and saw various changes to meet the needs of the people staying at the time. Rotas were created and planned in advance by the deputy manager. On the day of inspection there were four care assistants, a deputy manager and a registered manager on duty, supporting nine people that used the service. The deputy manager and the registered manager were supernumerary, but supported people when required.

During our inspection we observed there was a constant staff presence. We saw when people asked for support, staff were there to engage with them. We observed staff had time to sit and talk with people or complete an activity with them. This showed us the service had sufficient staffing levels to support people effectively.

We completed a tour of the premises and inspected people's bedrooms and communal living spaces. Heating to the home was provided by covered radiators thus protecting vulnerable people from the risk of a burn from a hot surface. We saw fire-fighting equipment was available and emergency lighting was in place, although at the time of inspection there was a fault on the emergency lighting system which had been reported to the local authority who owned the premises. From our discussions with the registered manager we concluded any issues with the premises had been reported in a timely manner. Furnishings and décor in communal areas and bedrooms looked comfortable and homely.

During our inspection we found all fire escapes were kept clear of obstructions. We saw upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. We saw the premises was clean and well maintained and equipped with specialist equipment such as an electric tilting bath, stretcher bath, hoists, wheelchairs and a specialist bed used for specific people. Other person specific equipment was loaned by the local authority as required.

The service employed a maintenance person two days each week. This staff member undertook a weekly check on the interior and exterior of the building to ensure it was safe and appropriately maintained. We spoke with the maintenance man who told us they monitored a lot of the health and safety records. We looked at these records and found regular checks on equipment and water temperatures were recorded. Where anomalies were documented, action had been taken to resolve the issue. For example, the water temperature check in two bedrooms had given readings higher than the permitted 43 degrees centigrade. The maintenance man told us and we saw evidence that new valves had been fitted as a result. Inspection of fire equipment, portable appliance testing on electrical items and servicing for lifts and hoist were documented. We asked to see the gas safety certificate and the 5 year hard wiring test which were forwarded to us. We concluded maintenance issues and health and safety concerns were dealt with promptly and appropriately.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked the registered manager how many people were subject to a DoLS. They told us one person had a DoLS in place and others had been referred. The registered manager had a separate document to monitor applications for people. We asked if any conditions were in place and the registered manager told us there were none which was confirmed by our review of the paper work. We saw the documents were in date and referred to a mental capacity assessment followed by a best interest meeting. This showed us the staff were working in-line with guidance.

We asked staff about their understanding of MCA and DoLS. They told us basic details relating to their role and what it meant for the people they supported. We saw evidence that a capacity assessment had taken place when there was doubt about someone's capacity to make their own decisions. One person's capacity assessment indicated small day to day decision could be made by the person and larger decisions including medical and financial decisions were to be made through a best interest meeting. We saw minutes to show best interest meetings had taken place.

We saw examples of consent sought. For instance, some people had no photograph on their MAR chart since they either had not given consent or the service was awaiting their consent.

All of the staff we spoke with felt the provision of training opportunities met their developmental needs. One member of staff told us, "The training is useful," whilst another said, "Overall, yes it good."

When new staff started they were required to undertake an induction training process to explain what was expected of them, and to provide an opportunity to familiarise themselves with the organisation's policies and procedures. The induction process was completed and signed off by the registered manager. Part of the induction process included shadowing a more experienced member of staff until new staff members felt able to work unsupervised.

There was an on-going training programme in place to ensure staff received training in a wide range of subjects pertinent to their roles and responsibilities. We looked at the training matrix for the service and

found regular training occurred. Staff were reminded when they were due training so they could apply for the course. All staff mandatory training had been completed and was up to date with the exception of people who were off sick or on maternity leave. We also looked at additional courses that were specific to the service. For example, we saw courses were available in subjects such as dignity and respect, risk management, diabetes, diabetes medicines administration and Islamic and Muslim Culture.

Throughout our inspection we saw staff supported and communicated well with each other, working well as a team. This observation was supported by comments made by the staff. Staff had recorded documents in their files of recorded supervision meetings with a senior staff member and documented annual appraisal meetings. All recorded meetings were a two way process and effective in their nature. Staff told us they felt well supported by the registered manager.

Good communication was noted from relatives and healthcare/social care professionals. A relative told us, "Staff have good communication, brilliant they are." A health care professional told us, "I have a lot of contact with them. We email or they speak to me if they've any problems." Another healthcare professional told us staff communicated with them well about people's needs, health and any issues.

We saw staff had the knowledge and skills required to carry out their roles and responsibilities. A healthcare professional gave us an example about how the staff had cared for a person with complex needs and told us, "They are very good at handling people."

People's care records recorded their likes and dislikes regarding food. Members of staff felt the choice and quality of meals was good. Comments included, "People get what they want," and, "They choose what they have." We found people's dietary and nutritional requirements were met and people were encouraged to consume a good and varied diet. For instance, we heard a member of staff encouraging a person to eat breakfast, saying, "Have you had some porridge? It's really nice, really good." A relative told us, "[Person] eats well here, usually puts on some weight."

We saw those people that required special diets received food of their choice in a form that suited their needs. The service had a four week rolling menu that was changed seasonally. However people were still given options of what they wanted to eat and we saw one person ask for something that was not on the menu and they were supported with this. People had their nutritional intake monitored with regular weight checks and use of the Malnutrition Universal Screening tool (MUST). We saw information in one person's care files that they struggled with eating food at home. However when they stayed at the service they consumed a wider variety of food and gained weight.

We saw people were enjoying their meals. The portions were of a good size and food was appetising and nutritious. We also noted that fluids were readily available at meal times and throughout the day to ensure people remained hydrated.

People had access to health care professionals and staff had sought advice from external health care professionals to support people with their health care needs. We saw people's care records included decisions made with support from district nurses, GPs, physiotherapists and chiropodists. Staff told us if they noticed someone's needs had changed, then this would be mentioned to the registered manager and an appropriate health professional would be requested to support them. For instance, we saw one person's records identified they had started to develop a pressure sore and a district nurse had attended to advise. One family member we spoke with told us they had confidence if their relative needed additional help, they would get it.

Is the service caring?

Our findings

A relative told us, "Very good care, [person] is very content. The staff know their stuff and are very good. Staff know [person] very well and they would be able to tell if something was not right. I have never seen [person] as settled."

A health care professional commented, "I applaud the staff at Glenholme for all their hard work and commitment into developing a service that promotes person centred approaches which is safe, effective and responsive and have been impressed with the positive behavioural support that is individually tailored to each person accessing their service. Care is paramount to the individual." Another healthcare professional we asked about the care at the service told us, "The staff are great. They have a good rapport with people. Is a relaxed atmosphere."

We saw people were seen to be at the centre of the service and of the care planning. The registered manager told us, "I think we look after them really well."

During our inspection we noted many positive interactions between staff and people that used the service. For example, we saw a member of staff come to sit next to a person, chatting with them and singing songs they enjoyed. Another person had returned from hospital on the day of the inspection. We saw staff welcome them back to the service and other staff from around the building come to see them and ask how they were. The person was clearly very happy to see staff. Another member of staff was chatting with and complimenting a person, saying, "You've been helping [person's name] today, haven't you? You were helping in the garden yesterday. Good job. It's lovely to have a nice garden isn't it?"

Staff had excellent knowledge of people at the service and were able to tell us about people's likes, dislikes and care needs.

People were encouraged to maintain their independence as much as possible. One healthcare professional we spoke with told us, "They get them to do as much as possible and help with laundry." We saw there was a kitchen upstairs where people who wanted a greater level of independence could make their own meals and drinks. However, the registered manager told us people at the service at that time preferred not to utilise this and this was their choice. We asked staff what they did to support people with their independence and they told us they supported people to do as much as they could for themselves. They gave examples, such as making some of their own food at meal times, walking unaided or supporting them with decision making. On the day of inspection we observed people being promoted and supported to do things themselves. One family member told us staff supported their relative to be more independent.

People were treated with dignity and respect. For instance, staff knocked on people's bedroom doors before entering and we heard staff speaking to people with respect. A healthcare professional told us, "They always knock on doors and don't presume to walk in. They always ask if I want a private room to talk to [person's name]." We noted the registered manager asked people's permission before showing us their bedrooms when they were showing us around the home.

People's confidentiality was respected. For example, when we were initially asking a staff member about their knowledge of people, until we offered reassurances they were reluctant to speak about specific people due to concerns about maintaining confidentiality. We also observed a person's family member visiting the service who had not been before. They were asked to wait in the entrance whilst a staff member verified the person knew the visitor, then asked if they wanted some personal space for the visit.

The registered manager and staff told us family and friends were encouraged to visit whenever possible.

Is the service responsive?

Our findings

A health care professional commented about the service, saying, "I find it to be flexible and adaptable in terms of meeting a wide range of needs and tailoring support packages at short notice. The provider works in partnership with the local authority and is willing to work to adapt the service in order to meet changing needs." Another healthcare professional said, "They're so on the ball and respond really quickly."

We looked at three people's care records which were organised in a logical order with an index for easy access to certain records. Care plans were present for areas of support each individual required. For example, we saw care plans in place for communication, mobility, keeping safe, personal care and level of understanding. Care plans were written in a person centred way and contained specific details relevant to each person. For example, one person's care plan stated, 'I prefer to walk hand in hand but I can walk unaided' and, 'Dry my hair straight after a shower.' Care plans listed people's likes and dislikes as well as their anxieties and fears. This meant staff had relevant information to support people appropriately.

We made observations during our inspection and we saw staff following people care plans, ensuring they were supported in an appropriate way that suited their needs. For example, we saw staff encouraging one person to walk unaided and another staff member discreetly asked someone if they required the toilet. We also saw where exercise had been identified as 'very good' in a person's care plan a staff member asked them if they wanted to have a short walk. They replied, "Yes", and they walked up and down the corridor.

We spoke with staff and they told us how they supported individuals. Staff told us due to the service being a respite unit, it was very important to have effective care records. The information they gave us matched information in the person's care records. This showed us care records were effective documents used by staff.

Care plans were reviewed on a regular basis. We saw one plan had been updated following advice from a health professional and another person's plans were reviewed when they returned to the service. This showed us care plans were up to date to reflect people's current needs.

A wide range of activities was on offer, many of which involved promoting people's independence. These were person specific and chosen by the people that used the service and included bowling, games, shopping, day trips and going out for meals. For instance, we saw in the activities diary that staff had suggested doing baking one evening. People had rejected this idea and they played bingo instead which was what people had chosen. A relative told us, "They have good activities and they support [person's name] to be independent."

We saw the service responded to people's personal preferences. For instance, staff walked into a room where a person was sitting with a noisy talk show showing on the TV. This prompted the staff member to ask if they wanted the channel changing. The person said, "Yes," and then became interested with what was being shown on another channel. We heard one staff member asking another what they were doing with a person on the day of inspection. The second staff member responded, "I don't know, I haven't asked what

they wanted to do yet."

The registered manager showed us the art room upstairs which was used when people requested or were art orientated. We saw the room was in regular use, although the registered manager told us, "It's up to them. Sometimes they won't want to do it." A 'pampering room' had recently been introduced at the service, where people could have their hair or nails done, listen to music, use the computer with Wi-Fi or watch DVDs. One of the large downstairs lounges contained a pool table, a table top football game, and an air hockey table, as well as games, DVDs and music CDs. A separate kitchen upstairs allowed those people who wanted greater independence to prepare their own meals and drinks. The service had recently purchased seven tablets for people to use and we saw one person playing a game on one of these during our inspection.

We saw the service had a robust complaints procedure in place. Leaflets from both the provider and the local authority containing information about how to make a complaint were displayed in the entrance hall. The provider leaflet also requested information about compliments and suggestions. All complaints were investigated and followed up although we saw there had been no official complaints since July 2015. A relative told us, "I know how to complain but I don't have to. I'm very happy overall."

We also saw evidence of a number of compliments received by the service which included, "Amazing staff at Glenholme," and, "You are all stars."

Is the service well-led?

Our findings

The registered manager was highly praised by staff, visitors and healthcare professionals. We saw a comment in the compliments file from a healthcare professional which said, "Your hard work and dedication within St. Anne's has been well commended within our team. Keep up the good work." Another healthcare professional told us, "[The registered manager] is lovely. Very amenable. Very helpful. There's good contact."

Staff told us they felt well supported by the registered manager and were able to approach them with any issues or concerns.

From speaking with people, visitors and health care professionals we concluded the service had a committed and passionate management team supported by staff. We saw the registered manager had a visible presence in the home and was well respected. We saw people clearly felt able to approach them with any concerns.

The culture in the service was open and honest and the registered manager told us they were constantly striving to improve the service for the people they supported. We saw where incidents or complaints had occurred, these were analysed, lessons learned and action plans put in place to reduce the risk of repeat occurrences.

The service had recently won an award from the provider as 'Top Team of the Year 2016' for their work with supporting people to manage any behaviours that were challenging to staff and others and de-escalation techniques. The registered manager told us this was out of over 50 teams or services.

We saw a number of audits were carried out on a regular basis including daily medicines audits, care plans, safety and internal and external building audits with improvement action plans where required. In addition, medicines were externally audited annually by the local pharmacist. The service also returned a monthly audit to the local authority which included information including staffing levels, accidents and complaints.

We saw documented records of monthly provider area manager visits to support and monitor the quality of the service.

From our observations and speaking with people, visitors and staff, we concluded people were involved in the service on a day to day basis, although residents meetings were not in place due to the respite nature of the service.

We saw from minutes reviewed that staff meetings were held on a regular basis, covering topics such as safeguarding updates, people's welfare, feedback and sharing 'best practice'.

Notifications to the Care Quality Commission were received appropriately and in a timely manner.